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ABSTRACT

The purpose of this report is to identify the physical and emotional health needs of the Indochinese refugees; to describe the efforts being made to respond to these needs both in the United States and overseas; to discuss the complications that still exist in the physical and mental health care delivery systems for refugees; and to assess recommendations made by public and private agencies to improve these services. The paper examines health conditions in the First Asylum Camps, overseas medical screening procedures, documentation and notification procedures, overseas immunization programs, the National Delivery System for physical health care, and the role of Medicaid and federally funded medical assistance programs. Also discussed are health care at the local level, emotional health needs of refugees, the role of social services in refugee mental health, and strategies for improving mental health care. A glossary of medical conditions and a selected bibliography conclude the report. (Author/JCD)

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Special Report:

Physical and Emotional Health Care Needs

of Indochinese Refugees

UD 21618

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March 20, 1980

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GLOSSARY OF MEDICAL CONDITIONS

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SPECIAL REPORT:

PHYSICAL AND EMOTIONAL HEALTH CARE NEEDS
OF INDOCHINESE REFUGEES

Indochinese refugees arriving in this country have been subjected to prolonged conditions of severe physical and emotional stress. The marks of their ordeal are plain -- these include significant personal medical problems and deep psychological wounds.

The purpose of this paper is to identify the physical and emotional needs of the Indochinese refugees; to describe the efforts being made to respond to these needs, both in the United States and overseas; to discuss the lags, complications, and gaps that still exist in the systems of physical and mental health care delivery to the refugees; and finally, to assess the recommendations made by public and private agencies to improve these services.

The full extent of our knowledge about the medical and emotional needs of the refugees is partially obscured by language barriers and cultural distance, but we do know that the problems which exist are basic to human life and well-being. The Indochinese refugees are neither a sickly nor an unstable people; they have weathered their hardships with remarkable stamina. They do, however, need special care and attention. The problems of the refugees need not threaten us, but rather should move us to respond more quickly. While we may never fully erase the scars of their violent uprooting and loss, we must do all that we are able in order to generate an efficient, effective and humane response to their needs.

The United States has ample means to devise comprehensive programs for physical and mental health care -- yet we have been slow to act. Our tardiness has only aggravated the existing troubles. The Indochinese refugees coming to this country find that their

problems often go uncared-for, either through poor coordination of services, lack of specific expertise, scarcity of resources, or simply an inability on the part of health care providers to locate the refugees once they reach our communities.

Several important improvements have recently been made in medical programs for refugees -- improvements that should do much to clarify the functions and responsibilities of the many people involved in refugee health care. Increased attention, at all levels, is being focused on the emotional health problems of refugees, in an effort to ease the stress and concern of the difficult period of resettlement. There is still a pressing need, however, both to further define and coordinate the roles of the public and private agencies involved, and to enlarge the scope of health and mental health care throughout the whole resettlement program, so that services vital to adjustment will be available to all who need them.

I. PHYSICAL HEALTH OF THE REFUGEES

A. An Overview

From the camps in Southeast Asia to communities in the United States, a host of individuals and a wide variety of international, national, and local organizations, are involved in providing medical care to the Indochinese refugees.

The United Nations High Commissioner for Refugees (UNHCR), in cooperation with the host country's national government, and in collaboration with other international and national agencies, takes responsibility for the health and welfare of all refugees in the first asylum camps. Those refugees who are accepted for resettlement in the United States travel from the camps to transit centers, also

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administered by the UNHCR. The Intergovernmental Committee for European Migration (ICEM), provides medical screening^{*/} in the transit centers, and arranges transportation to the U.S.. The Center for Disease Control (CDC), a branch of the U.S. Public Health Service (USPHS), monitors this overseas screening and examines the refugees' health records at U.S. ports of entry.

According to the U.S. Public Health Service, once the refugees arrive in the areas of their intended resettlement, the primary responsibility for providing health services rests with the state and local health departments. The voluntary resettlement agencies, and the local sponsors who have been located for the refugees by the voluntary agencies, complement the efforts of the state and local health departments both by assisting the refugees in health-related matters, and by encouraging the donation of services by private physicians, clinics, and hospitals.

The medical services provided to the refugees are generally covered by the Medicaid program, which is administered by HEW's Health Care Financing Administration (HCFA). Though the expense for Medicaid benefits is normally shared between the state and the Federal government, in the case of the Indochinese refugees, the state's share of Medicaid expenditures is reimbursed, through special Federal legislation, by HEW's Indochinese Refugee Assistance Program (IRAP), which is administered by the Office of Refugee Affairs, in the Office of the Secretary of HEW.^{**/}

^{*/} Overseas screening consists of a preliminary, cursory examination for active tuberculosis, syphilis, infectious leprosy, and other excludable conditions, as designated by the Immigration and Naturalization Service (INS). Screening provided to refugees in the U.S. is generally termed an "initial health assessment", and involves more extensive procedures, which will be discussed later in this paper.

^{**/} The Office of Refugee Affairs is currently shifting from the Social Security Administration to the Office of the Secretary of HEW.

Many of the Indochinese refugees arrive in this country with significant health problems. Data provided by the U.S. Public Health Service suggests the prevalence of the following conditions: ^{*/}

Intestinal parasites	31 percent
Anemia	29 percent
Skin conditions	28 percent

Malaria, Hepatitis B, and dental problems are also frequently encountered medical conditions. The incidence of tuberculosis among the refugees has been a subject of concern to some health officials. The Public Health Service has noted, however:

"....the rate of active tuberculosis in absolute terms is probably below one percent in those entering the country...The number of infectious TB cases which might slip through the overseas screening process is exceedingly minute."

While the medical troubles of the refugees warrant prompt attention and care, the majority of problems are not severe. Preliminary data from a recent sample-screening of incoming refugees conducted by the Center for Disease Control (CDC), indicated that only one-tenth of one percent required immediate hospitalization, and 94 percent were within the normal limits of good health. A Public Health Service team that assessed health care for Indochinese refugees on the West Coast, reported:

"...when the existing systems are functioning well, as appears to be the case for a substantial majority of the arriving refugees, the risks to the American population are probably lower than those which characterize routine immigration."

In other words, the refugees pose no serious health threat to the population at large. However, the provision of adequate, personal health care to the Indochinese refugees, has presented significant

^{*/} See the Glossary at the conclusion of this report for a more precise description of these medical conditions.

logistical problems. Hospital based services and emergency care pose no apparent difficulties; but the PHS team noted:

"The needs of refugees for ambulatory care, such as screening, diagnosis, immunization and other preventive care, and nutritional, dental and mental health care are not being adequately addressed."

The efforts by state and local health departments to provide satisfactory, timely medical care, have been greatly hampered by a number of procedural complications. These include:

- Overseas medical screening of the refugees has often been incomplete and inconsistently reported.
- State and local health departments have frequently not been provided with adequate information as to the number of refugees arriving, or their intended residence. Local health providers are thus hindered both in planning and promptly initiating service delivery.
- Funding resources are limited (in some places critically) for the provision of health services to refugees. Delays in Medicaid certification have also impeded the delivery of service.
- Language and cultural barriers present special difficulties.

B. Health Conditions in the First Asylum Camps

There are approximately 40 first asylum camps throughout Southeast Asia, the majority of these in Thailand, Malaysia, and Indonesia. The first asylum camps provide a temporary residence for the 250,000 Vietnamese, Cambodian, and Laotian refugees seeking permanent resettlement in other countries. ^{*/}

*/ This figure does not include the 140,000 Cambodians, fleeing the war and famine in their country, who have been placed in four UNHCR/Thai government "holding centers" in Thailand; nor does it include the estimated 370,000 Cambodians camped along the Thai/Cambodian border. These Cambodians expect to return to their own country eventually; thus they are not currently considered candidates for resettlement.

The provision of health care in the first asylum camps is dependent upon the cooperation of the host governments of the various Southeast Asian countries with the UNHCR and numerous other international relief agencies. Medical personnel applying to serve in a first asylum camp must be approved by the host government involved--a process that can often be complex and time-consuming.

According to relief agency personnel and federal officials, health conditions in the first asylum camps have generally been improving since the summer months of 1979, when refugees were arriving in the tens of thousands. In June and July of that year, a U.S. Public Health Service team conducted an extensive tour of the camps and transit centers. They found severe overcrowding everywhere, and limited medical and sanitation facilities in many of the camps and transit centers. Drug supplies were extremely scarce in a number of camps, and immunization programs against vaccine-preventable diseases (including cholera, smallpox and the seven childhood diseases--diphtheria, pertussis, tetanus, measles, mumps, rubella, and polio) were adequate in some places, and virtually non-existent in others. The Public Health Service team did note, however, that the camps appeared to have adequate supplies of food, with good nutritional balance. Malnutrition, when observed, "was not associated with insufficient food or inadequate diet at the camps, but as a result of deprivation in the refugees' homeland or while en route to the camps."

Several developments over the last six months suggest that there have been significant improvements in the general health conditions in the first asylum camps and transit centers. Perhaps

most importantly, the overall refugee population in the first asylum camps has decreased by more than 120,000 people since the end of July. (This is due both to an increase in the worldwide resettlement effort, as well as to a slackening in the number of refugees fleeing Vietnam and Laos.) This decrease in overall camp population has eased the overcrowding in many of the camps, and given medical staffs an opportunity to improve their facilities and services.

Public Health Service personnel are now working in several of the larger transit centers in Southeast Asia, monitoring and developing medical screening procedures and other medical services. Additional PHS personnel have been made available to the various host countries to assess and improve health services in a number of the first asylum camps.

The U.S. Public Health Service has also developed immunization programs for Indochinese refugees in the transit centers, and has improved the flow of refugee medical records from the transit centers and first asylum camps to the United States.

C. Overseas Medical Screening Procedures

All refugees who have otherwise been approved for resettlement in the United States, must pass a medical examination, administered by ICEM, before they can travel to the U.S.. This screening may be conducted at the first asylum camps by mobile medical units, or in the transit centers by ICEM medical officers. The examination consists of the following procedures:

- 1) Brief medical history of present or previous illnesses.
- 2) Serum test for syphilis, for refugees 15 years or older.

- 3) Visual exam for leprosy and other skin conditions.
- 4) Chest X-ray for all refugees 15 years of age and older.
(Chest X-rays are taken of children 15 and under when they exhibit symptoms of TB or when a family member is diagnosed with TB.)
- 5) Observation for any excludable mental conditions.

The basic purpose of the overseas screening is to determine whether any refugees approved for resettlement in the United States are to be excluded for medical reasons. Excludable conditions, as defined by the Immigration and Nationality Act, are designated "Class A." They include the following:

- 1) Five venereal diseases - syphilis, gonorrhea, chancroid, granuloma inguinale, and lymphogranuloma venereum. (These conditions are not excludable if they are adequately treated.)
- 2) Active tuberculosis. ^{*/}
- 3) Infectious leprosy.
- 4) The following mental conditions:
 - a. mental retardation
 - b. insanity (past or present)
 - c. severe personality disorders, including chronic alcoholism, and drug addiction

The Public Health Service team reported that the screening procedures they observed in the transit centers and first asylum camps this past summer needed improvement. To better assure the quality and precision of the medical screening process, 6 Public Health Service personnel have been assigned to the transit centers in Bangkok, Kuala Lumpur, Singapore, and Hong Kong.

Refugees who pass the medical examination usually leave for the United States within 24-72 hours of the screening. Those with indications of excludable conditions are given a more comprehensive

^{*/} Tuberculosis and leprosy are discussed at greater length in the Glossary at the conclusion of this report.

The growth in transit center population due to medical delays means that a high concentration of refugees with significant health problems are grouped together in cramped, often insanitary, conditions. Limited medical services are thereby further strained, and the risk of transmission of disease is increased. In addition, the overcrowding in the transit centers has hindered rapid processing of refugees for medical screening.

To relieve the overcrowding caused by medical delays, both health and immigration officials are considering various ways to streamline the waiver process for Indochinese refugees. One idea being discussed is the suspension of active, but non-infectious tuberculosis^{*/} as an excludable condition. Virtually all health officials share the opinion that this condition poses no serious public health threat to the U.S. population, and could be treated more properly and effectively in this country.

Under the existing system, refugees with active tuberculosis who do not qualify for a waiver, are placed on medical hold until their tuberculosis has been re-classified as inactive. If the necessity for a waiver is suspended, then all refugees diagnosed with active, but non-infectious TB would be able to emigrate within a few days of their medical examination. Once in the United States, they would be referred immediately to the local health department in their area of intended resettlement. Under no conditions would individuals with infectious tuberculosis be allowed into the United States.

^{*/} It must be stated that active tuberculosis is not always infectious. Under no conditions are refugees with infectious tuberculosis eligible for entry into the United States.

physical examination. If an excludable condition is identified, then the refugee is placed on medical hold and may be denied entry into the United States, unless he or she qualifies for a medical waiver.

D. Waiver of Excludability

Refugees with certain excludable conditions (active, non-infectious tuberculosis; ^{*/} mental retardation; or a previous attack of insanity followed by a demonstrated one-year period of recovery) will be allowed to enter the country only if they meet the qualifications for a "waiver of excludability" from the Immigration and Naturalization Service (INS). Refugees with the above excludable conditions are placed on "medical hold," and can receive a waiver only after: (1) they demonstrate the presence of immediate familial relationships in the U.S. (spouse, parent, or child), (2) the waiverable condition is determined to be under medical care in the camp or transit center, and (3) sponsorship in the U.S. has been reconfirmed. Narcotic addiction, chronic alcoholism, and infectious leprosy currently prohibit a waiver.

Approximately 4 percent of the refugees screened have an excludable condition; about 25 percent of this group qualify for a waiver. Placing these refugees on medical hold has resulted in the steady growth of a resident population--particularly at the transit centers, but also at those first asylum camps where medical screening occurs. Completion of the waiver process usually takes two to three months. Those refugees who do not qualify for a waiver may wait six months to a year under medical care before their conditions are no longer considered so severe as to be excludable.

^{*/} Note footnote on page 10 of this report.

Kong, and Kuala Lumpur. As the program is currently set up, only those refugees emigrating to the United States will be receiving the vaccinations.

F. Documentation and Notification Procedures

When the refugees have completed their overseas medical screening and have been cleared for travel to the United States, they leave the camps and transit centers either on a chartered airline or a regular commercial flight. On all charter flights, there is a volunteer physician and/or nurse on board. ICEM also provides a nurse on all regular commercial flights carrying more than 100 refugees. Pilots radio ahead in the event of any medical emergency, so that the necessary care will be available on arrival.

Only a small fraction of the incoming refugees require immediate medical attention. State and local health providers, however, have been concerned that, until recently, they have been largely uninformed as to refugee arrivals in their area. They have been hampered in their efforts to provide adequate health care to the Indochinese refugees by 1) the lack of timely information on the arrival of refugees and 2) the frequent inadequacy and absence of refugee medical records.

Refugees have quite often arrived at U.S. ports of entry without important medical documents describing the results of tests done overseas. When the documents are available, the information is sometimes inaccurate or questionable. Until recently there has been no effective system to assure that local health care providers obtain all of the necessary records of screenings done in the camps and transit centers. However, the Public Health Service is now monitoring the overseas screening process--in order to

Another idea currently being discussed to relieve the problems caused by medical delays is the suspension of the requirement that refugees must have familial relationships in the United States in order to qualify for a medical waiver. Ultimate authority to change immigration regulations for refugees (aside from those regulations which are mandated by statute) rests with the Attorney General of the United States, though the Department of State, and the Department of Health, Education, and Welfare are involved in the decision-making process.

E. Overseas Immunization Programs

In their tour of the refugee camps and transit centers in Southeast Asia this past summer, the Public Health Service team explored the feasibility of initiating immunization programs for Indo-chinese refugees scheduled for resettlement in the United States. The team considered it particularly important to immunize refugee children against the seven traditional childhood diseases--polio, diphtheria, pertussis (whooping cough), tetanus, measles, mumps, and rubella (German measles). They suggested that:

"...if a well-documented and well-organized program were carried out in the camps under sponsorship of the UNHCR, most refugees, especially children, could complete their immunizations prior to medical screening."

Immunization programs developed by the U.S. Public Health Service have been fully operational in the transit centers since early February. The Department of State has appropriated the necessary funds, and ICEM has agreed to administer the immunization program. Vaccinations for all seven childhood diseases are being given at the five major transit centers--Bangkok, Manila, Singapore, Hong

ensure both the quality of the medical testing and the accuracy of the documentation. In addition, PHS has recently implemented a system for notifying state and local health officials of initial refugee arrivals in their area. The system should provide health officials not only with the number and location of incoming refugees, but with copies of all important medical documents as well.

The Public Health Service notification system works as follows: When refugees arrive at a U.S. port of entry, they have in their possession a folder containing various documents which are reviewed by a Quarantine Officer of the Center for Disease Control.^{*/} The three documents that are of concern to the Quarantine Officer are:

1. Voluntary Agency Form ACVA-1. (This form contains the refugee's INS alien registration number, and the names of all persons in the refugee's family. The form also designates the voluntary agency which arranged sponsorship, the city of destination, and the refugee's date of entry. Immunization records will be attached to this form.
2. Medical Examination Form OF-157. (This form describes the results of the overseas screening procedures, and indicates those health conditions that warrant prompt attention, particularly Class A [i.e., active] tuberculosis.)
3. Chest X-ray for tuberculosis.

The refugees present the ACVA-1 form to the Quarantine Officer, who in turn mails copies of the form to the appropriate state health officer and local health officer, as well as to the Quarantine Division of the Center for Disease Control in Atlanta, Georgia.

For refugees with active (Class A) or inactive (Class B) tuberculosis, the Quarantine Officer at the port of entry mails copies

^{*/} In addition to processing refugee medical documents, the Quarantine Officer makes a cursory visual inspection of the refugees and refers those who are visibly ill to immediate medical care.

of the OF-157 form to the state health officer, the local health officer, and the Quarantine Division, CDC. The Quarantine Officer, at the same time, will notify the local health department, by phone, of the arrival of any refugees with active tuberculosis, so that preparations can be made to provide the necessary medical care.

In addition to their medical documents, refugees coming into the country will soon carry two introductory letters drafted by the Public Health Service. One letter, which the refugees will be requested to present to their sponsors, explains the necessity of a prompt, initial health assessment for each refugee. The other letter, which is to be presented to the health care provider, describes the medical services which the Public Health Service has suggested be given to all Indochinese refugees.

G. The National Delivery System for Physical Health Care

The Public Health Service has stated that Indochinese refugees entering the United States pose no serious public health threat to the population at large. Many of the refugees do have significant personal health problems, however, and these problems require prompt consideration and care. The Public Health Service has recommended to state and local health departments that the following health services be provided to Indochinese refugees:

- General evaluation for medical problems, including those related to malnutrition.
- Visual screening for significant skin conditions.
- Immunizations, particularly for the seven childhood diseases.
- Any procedures, such as further evaluation for tuberculosis, indicated by the results of the overseas screening tests.
- Treatment of any serious medical problems, and referral to a continuing source of medical care.

The provision of these health services -- and other related services, such as family health care counseling, health services orientation, and translation -- involves numerous public, private, and voluntary agencies working at the national, state, and local level. The Public Health Service emphasizes that primary responsibility for providing, and/or locating, health services for refugees lies with the state and local health departments. Health care providers, public and private, in many areas of the country, however, have faced considerable difficulties in adapting their resources to meet certain special needs of the Indochinese refugees:

- Language barriers are the most obvious difficulty. Interpreters are frequently hard to locate; communication between the health care provider and the refugee, even with an interpreter, can sometimes be a slow and inexact process.
- Outreach efforts to ensure that refugees become familiar with health services in their community, are frequently inadequate.
- Great disparities exist between the American system of health care and traditional Indochinese methods. These differences can give rise to misunderstanding and frustration on all sides if cross-cultural education programs are not initiated.

In addition to these culturally-related barriers, local health resources in certain areas have been taxed with meeting the needs of a large refugee population.^{*/} To relieve the strain on local

^{*/} These areas, identified by HEW, are as follows: Florida (Pensacola, Tampa, Miami, and Jacksonville); Illinois (Cook County); Louisiana (Orleans Parish); Texas (Dallas, and counties in the Houston metropolitan area); California (Los Angeles, Orange, San Diego, Santa Clara, Sacramento, Alameda, Contra Costa, and San Francisco counties); Hawaii (Oahu); Washington (Seattle/King County); and Oregon (Clackamas, Multnomah, and Washington counties).

resources, the Public Health Service has offered the use of PHS facilities and personnel, both in these communities and throughout the country generally. These facilities include all Public Health Service hospitals and clinics operated by the Bureau of Medical Services. In addition, a variety of community health programs supported through the Bureau of Community Health Services, are available to Indochinese refugees.

HEW's Indochinese Refugee Assistance Program (IRAP), which is administered by the Office of Refugee Affairs, also assists state and local health departments by offering full Federal reimbursement to state programs that provide health, and health-related services to refugees.

Estimates indicate that 90 percent or more of newly arriving Indochinese refugees are eligible for medical benefits under the Medicaid program-- Title XIX of the Social Security Act. ^{*/} Medicaid programs are primarily state-administered, though supported by state and Federal matching funds. However, when health services covered by a state's Medicaid program are provided to eligible Indochinese refugees, the federal government covers the state's share of the expenses.

HEW's Indochinese Refugee Assistance Program also provides full Federal reimbursement for social services provided to eligible refugees under Title XX of the Social Security Act. IRAP reimburses the states for such things as translation and interpreter services, and for important health-related services that include:

^{*/} These benefits, which include hospital, laboratory, and home health care services, are described more fully on page 18 of this report.

"Information; referral to appropriate resources; assistance in scheduling appointments and obtaining services; and counseling to individuals or families to help them understand and identify their health needs, and maintain or improve their health."*/

In addition to reimbursing the states for Medicaid benefits and social services provided to eligible Indochinese refugees, IRAP has been reimbursing the Bureau of Medical Services of the Public Health Service for the provision of necessary health services to the refugees. With eight general hospitals and 27 clinics nationwide, the Bureau of Medical Services has been giving initial health assessments as well as treatment to refugees. Their guidelines and operating budget enable them to serve only specially designated groups (such as merchant seamen, for example), so their costs in providing health services to refugees have been covered by IRAP through a special interagency agreement.

H. Role of Medicaid and Federally Funded Medical Assistance Programs

The effects of the improvements recently made in the overseas screening process, the immunization programs, and in the documentation and notification procedures, are expected to become increasingly evident in the coming months. It is also expected that health care providers will have an easier time in locating the Indochinese refugees in their communities and in identifying their health needs. However, there is still a considerable problem that has yet to be satisfactorily resolved: The complexities and dis-

*/ According to an IRAP program directive of August 24, 1979, these health-related services may be provided to refugees without regard to age or family income.

parities of the states' Medicaid programs continue to hinder prompt access to the public health care system, and frequently deny refugees crucial services -- including, in some cases, an initial health assessment.

Every state in the United States, except Arizona, has a Medicaid program. Title XIX of the Social Security Act requires that every state Medicaid program offer these basic services: hospital services, laboratory and X-ray services, skilled nursing facilities and home health care^{*/}, physician services, family planning, rural health clinic services, and, for individuals under 21, early and periodic screening, diagnosis, and treatment (EPSDT) services. States may also offer a variety of optional services, including dental care, and screening and diagnostic services.

The EPSDT program approximates the Public Health Service's recommended health services for Indochinese refugees. Required services under EPSDT include a general physical examination, immunizations, nutritional assessment, and dental services. States are also required to arrange for any necessary treatments and to provide transportation services.

Many state Medicaid programs, however, do not cover an initial health assessment for refugees 21 years of age or over. Since Medicaid programs are state-operated, HEW's Health Care Financing Administration (HCFA), which is responsible for the Federal aspects of Medicaid, has no authority to expand any state's Title XIX program. Therefore, IRAP officials are currently studying the possibility of either:

^{*/} The nursing facilities and home health care services are provided for individuals 21 years of age and older.

- 1) requesting a special appropriation to provide for initial health assessments for all Indo-chinese refugees, or
- 2) allowing initial health assessments to be covered as a social adjustment service under Title XX of the Social Security Act.

In order to qualify for the Medicaid program, Indochinese refugees must meet normal eligibility criteria for either the AFDC (Aid to Families with Dependent Children) program or for the SSI (Supplemental Security Income) program, which provides cash assistance to the aged, blind, or disabled. Eligibility criteria for these programs vary considerably from state to state. In reimbursing the costs of services provided under Medicaid, the Indochinese Refugee Assistance Program covers the state share of the expenses; the Health Care Financing Administration administers the Federal share of the funding.

Refugees who do not meet the normal eligibility criteria for the AFDC or SSI programs (single Indochinese refugees under the age of 65, for example), may still qualify to receive Federally funded medical assistance. Such medical assistance is technically not called Medicaid, though financial eligibility standards are similar. Medical services provided under this medical assistance program are the same as those offered under a state's Medicaid program. HEW's Indochinese Refugee Assistance Program covers the full financing of this program, rather than sharing the reimbursement with the Health Care Financing Administration (as is the case with Medicaid).

One factor that has hindered the prompt delivery of health care to the refugees is the delay involved in determining eligibility for Medicaid and medical assistance programs--a process which often takes up to six weeks to complete. Although health care providers are en-

titled to retroactive coverage for most of the health services they provide--and though estimates are that 90 percent or more of the newly arriving refugees are eventually found eligible for Medicaid or medical assistance--the frequent delays in certification nonetheless cause reluctance among many providers, and impedes the delivery of health services. Consequently, HEW officials are considering the possibility of operating on the basis of "presumptive eligibility," for all incoming refugees, for Medicaid and medical assistance. This "presumptive eligibility" would mean that refugees could receive medical services for a specified, short period of time--probably sixty to ninety days-- while normal procedures to determine Medicaid and medical assistance eligibility take place. This procedure would facilitate the refugees' receiving needed medical treatment soon after arriving in the United States.

I. Health Care at the Local Level

The impact of the many recent improvements in the national delivery system of health care to Indochinese refugees, will take some time to be felt at the local level. Health care providers must often simply make do with programs that have an uncertain future, are only partially in place, or are critically strained in terms of staff and resources. Local health care providers in some areas are still hampered by a lack of advanced notification of the arrival of refugees in their area, and difficulty in locating refugees once they arrive; poor communication of results of medical tests done overseas; and insufficient translation and transportation services for the refugees. Given these complications, however, the effective programs that have been fashioned in a number of local areas are testimony to the diligence and ingenuity of many people in public, private, and voluntary service.

In order to provide a sense of how a local system of health care operates, the following discussion offers a brief description of the medical services available to refugees in the Seattle/King County area. Seattle/King County's population of more than 7,000 Indochinese refugees has had a significant effect on a variety of local health care services.

In the Seattle/King County area, the voluntary resettlement agencies introduce refugees into a system of continuing health care at one of eighteen community health clinics. These community clinics receive reimbursement for providing Medicaid benefits, but they will also provide free care to all clients in need, with or without Medicaid.^{*/}

These eighteen community health clinics operate somewhat independently from the Seattle/King County Health Department, which is responsible for operating five district health clinics. The Health Department has also assumed primary responsibility for providing an initial health exam to all Indochinese refugees within the first week of their arrival in the area.

Since this past November, the Seattle/King County Health Department has been operating a mobile medical screening project. A team consisting of four interpreters (two Vietnamese, one Cambodian, and one Laotian), a nurse-practitioner, a nurse, a microbiologist, and a project coordinator, provide an initial health assessment to all newly arriving refugees. The team operates, on a rotating basis, out of three community health clinics and two district health clinics. The screening team works in the evenings, for the convenience of sponsors who need to provide transportation for the refugees.

^{*/} The clinics receive staff and/or financial support through such varied sources as the National Health Service Corps and the Urban Health Initiative (both programs of the U.S. Public Health Service), CETA, and city revenue sharing. They also can request payment on a liberal sliding scale.

The health assessment consists of a brief medical history, physical examination, immunization, blood test for anemia, any necessary treatment, and referral to a source of continuing health care. The project is reimbursed on a unit-of-service basis by the state Department of Social and Health Services, which is in turn reimbursed by the Federal government through the Indochinese Refugee Assistance Program.^{*/} In addition to the Seattle/King County Health Department's project, screening is also provided by the International District Health Clinic (the community health clinic most heavily used by refugees), and by two voluntary resettlement agencies--the International Rescue Committee (IRC) and Catholic Social Services.

The Seattle Public Health Service Hospital complements the work of the voluntary agencies, community health centers, Seattle/King County Health Department, and others, by providing emergency care and other hospital-based services. The PHS Hospital has also been actively involved in the coordination and planning of strategies for refugee health care in the area.

^{*/} Reimbursement for services that are not covered by Medicaid is allowable under a provision of a June 9, 1975 HEW policy instruction. The provision reads:

"...where additional medical services are required--and where such services would be available to destitute U.S. citizens through public facilities such as county hospitals--the state agency may purchase services for refugees from such facilities in order to avoid the refugee's becoming a burden on publicly funded local services."

It is unclear why more health departments have not taken advantage of this provision to expand their medical service programs to include an initial health assessment for Indochinese refugees.

Health care services compose an essential part of the refugees' new life in the United States, and it is important that these services be particularly responsive to the special cultural needs of Indochinese people. The cultural accessibility of health services can be enhanced through bilingual programs of community health education and personal health care counseling. These programs, which have been used in many communities around the country, are designed to present Western health care concepts in terms familiar to the Indochinese.

One idea that has been proposed is the specialized training of interpreters to work in a medical setting. These interpreters would be well-versed in both Western and Indochinese medical concepts and vocabulary, and would serve to ease some of the strain and confusion that often occurs between the health care provider and the refugee. Programs could also be established to train bilingual para-medical personnel, as well as to provide English language training and/or recertification for Indochinese physicians.

Bilingual and bicultural approaches such as these would assist refugees in their adjustment by enabling them to use health care services in this country more effectively and more comfortably.

II. EMOTIONAL HEALTH OF THE INDOCHINESE REFUGEES

Recently, mental health care for Indochinese refugees has been receiving increasing national attention. Mental health projects throughout the country have been working with an increasing array of people and needs. Their message has been clear from the very outset of this country's involvement with Indochinese refugees.

In 1975, Drs. Julius Segal and Norman Lourie, who were then studying the mental health needs of the Vietnamese refugees in Guam, wrote:

"...the provisions of mental health and social services should be given a distinct priority and visibility equal to other elements in the overall organization and administration of the refugee programs."

The common ground is scant between traditional Indochinese approaches to healing the mind, and Western methods of mental health care. There are deep cultural restraints among the Indochinese against revealing "weaknesses" of the mind. The result is that an extremely small percentage of the Indochinese population avail themselves of mental health services.

There is much information to suggest, however, that many of the Indochinese refugees are troubled by considerable emotional stress. This is brought on, in part, by the intense traumas of the violent uprooting from their homeland, separation from family and friends, and the long and uncertain periods of waiting in the refugee camps in Southeast Asia. Further, once in this country, they face the stress of cultural alienation, mixed reactions from the American people, language difficulties, and frustration with finding adequate work and housing.

Still vulnerable from their recent anguishing experiences, the refugees are confronted with the baffling complexities of resettlement and adjustment to a new life in this country. A significant cause of the depression that so many Indochinese refugees experience, is a sense of frustration and helplessness in coping with their new situation. Many of their frustrations can be prevented, or at least eased, by personal counseling and cultural orientation. This orientation and counseling should cover everything

identified over 1,000 organizations nationwide that were familiar with the mental health needs of the Indochinese refugees. These organizations were essentially of four types: voluntary resettlement agencies and their local affiliates, community mental health centers, Indochinese community organizations (sometimes also known as mutual assistance associations), and local mental health projects funded by HEW's Indochinese Refugee Assistance Program.^{*/} Each of these types of organizations has rather different functions, goals and capabilities.

The voluntary resettlement agencies play a pivotal role in attempting to ensure that the initial resettlement period proceeds as smoothly as possible for the refugees. The voluntary agencies are responsible for locating sponsors for the refugees. These sponsors, in turn, endeavor to make sure that certain basic needs--clothing, housing, employment, etc.--are met. The voluntary agencies, and the refugees' sponsors, have the opportunity to provide fundamental orientation services and practical assistance. They frequently do not have ready access, however, to bilingual mental health professionals and para-professionals trained to spot trouble signs and versed in special crisis counseling techniques.

There are approximately 700 community mental health centers in operation throughout the country, each supported initially by HEW's National Institute of Mental Health (NIMH). The community mental health centers provide subsidized mental health care to

^{*/} The IRAP-funded mental health projects include a number of programs and affiliates of the other three varieties, as well as a number of projects at state and local social service agencies, research and training institutes, and colleges and universities. The projects are funded specifically to provide mental health services to refugees. These services might include community outreach and orientation services, and the training of bilingual mental health workers. (See pages 28-30 for a fuller description of these projects.)

from language and job training, and advice about shopping, transportation, and other matters, to general explanations of American cultural values. The voluntary resettlement agencies and their local affiliates, and various state, local, and private agencies, are attempting to provide such counseling and orientation services to as many refugees as possible. Unfortunately, however, comprehensive programs are not generally available.

Despite the enormous strains of the adjustment process, a considerable number of refugees are most vulnerable to depression after the more immediate tasks of resettlement are completed--when the needs for food, clothing, housing, work, etc. are satisfied--and the newly settled refugees have time to reflect more deeply on their ordeal. In this period, too, the need for counseling and support is great.

There is no question that at least some--and perhaps much-- of the frustration and helplessness experienced by refugees could be avoided by better preparing the refugees, early on, for life in America. Language and vocational training are fundamental. Cultural understanding is essential. The more that is done, in the earliest stages of the process, to ease the period of adjustment, and to enable the refugees to feel comfortable and productive in their new environment, the more readily they will be able to cope with the inevitable desolation that comes when the full weight of their sorrow and loss strikes home.

A. Organizations Involved in Refugee Mental Health Care

A study conducted in the spring of 1979 by the Bureau of Research and Training, Pennsylvania Office of Mental Health, ^{*}/

^{*}/ The study, entitled "National Mental Health Needs Assessment of Indochinese Refugee Populations", was sponsored by HEW's Indochinese Refugee Assistance Program. (This study is listed in the Bibliography found at the conclusion of this report.)

essential to nurturing a sense of self-esteem and self-reliance among Indochinese refugees. The most essential service may in fact be the fundamental, natural bond of community that these groups provide. Such a bond is indispensable to mental and emotional well-being. These Indochinese organizations have been all too frequently overlooked, and thus often lack the resources to achieve their full potential.

Much of the direction in the area of mental health care for the refugees has been initiated by the special mental health projects funded by HEW. In fiscal years 1976 and 1977, the National Institute of Mental Health funded six projects to respond to the mental health needs of the refugees. On October 1, 1978, HEW's Indochinese Refugee Assistance Program awarded thirty-seven grants to public and non-profit private agencies for mental health projects designed "to assist refugees in resettling in the United States and in becoming self-reliant." These projects were developed and administered by the following types of agencies and organizations:

Voluntary Resettlement Agencies.....	11
State and Local Social Service Agencies.....	9
Research and Training Institutes.....	6
Community Organizations.....	6
Colleges and Universities.....	5

Each of these IRAP-funded projects was required to create an advisory board, composed of equal numbers of representatives from among the Indochinese community, mental health clinicians, and the social service agencies. In granting the awards, HEW has attempted to stimulate cooperation and a coordination of services among the many diverse organizations involved in refugee mental health care.

anyone within their given geographical area (otherwise known as a "catchment area"). The centers may be supported by any number of Federal, state, local, or private sources. They may also request nominal charges for services, adjusted according to the client's ability to pay.

The community mental health centers are frequently hampered in serving the Indochinese refugee community because their staffs usually do not possess any specific expertise in Indochinese culture, and hence do not always understand the special mental health needs of the refugees. In addition, because these centers do not usually have any bilingual staff, they are therefore not equipped to provide services to refugees whose English ability is not sufficiently developed. Officials from the National Institute of Mental Health have recently been investigating strategies to improve the outreach capabilities of community mental health centers operating in, or near, Indochinese communities. ^{*/}

The Indochinese community organizations (also called mutual assistance associations) are in an excellent position to offer newly arriving refugees much-needed information about housing, employment, and available social and health services. They are also able to provide valuable assistance in the development of useful, effective language and vocational training programs. The Indochinese community organizations are perhaps best aware, of any organizations assisting refugees, of those skills and services that are most

^{*/} NIMH is currently funding two research projects in the area of refugee mental health needs. These are located at the Pacific/Asian American Mental Health Research Center, in Chicago, and the Pacific Asian Mental Health Research Project, in San Francisco.

In order to receive funding, the projects had to develop programs designed to achieve any one, or a combination, of three major objectives: ^{*/}

- 1) Influencing the existing mental health services delivery system.
 - a. Development of training programs on such topics as: Indochinese perceptions of Western mental health practices; methods of treatment for the refugee population; etc.
 - b. Training sessions, conferences, and workshops aimed at improving mental health services provided to refugees.
 - c. Short-term research to identify the scope and nature of refugee mental health problems and the availability of treatment within the existing systems.
- 2) Increasing opportunities for employment in the mental health field for the Indochinese.
 - a. Development of training projects for Indochinese individuals, including both classroom and on-the-job training, and supervision by certified or licensed professionals.
 - b. Career planning for trainees.
- 3) Creating community support systems.
 - a. Development of interagency mental health forums, task forces, or committees--which include representation from the public and voluntary sectors, and from the refugee community--to coordinate activities.
 - b. Training and supervision for Indochinese paraprofessionals to function as outreach workers and counselors.
 - c. Creation of educational programs designed to acquaint the refugee population with services and facilities available to them.

^{*/} Much of the wording describing these three objectives is taken from the Federal Register (May 11, 1978), announcing the availability of funding for these projects.

Due to reduced Congressional appropriations, only thirty-two mental health projects received Federal funding through the Indochinese Refugee Assistance Program in fiscal year 1980. Virtually all individuals in the refugee mental health field hope that Federal funding for projects such as these will be continued. These special mental health projects form an integral and vital part of the refugee assistance program, and clearly should not be cut back.

B. Special Concerns in Refugee Mental Health

The family is the fundamental unit--the primary source of cohesion and continuity--in traditional Indochinese societies. There is an extreme cultural reticence among refugees to seek help for emotional problems outside the traditional bounds of family and close community. Profoundly different from the American concept of the nuclear family, the Indochinese family should be understood--in the words of one orientation guide--"as a superorganic unit existing across generations past and future." The allegiance to family passes beyond a sense of duty to a feeling of deep reverence, and actual worship. One's behavior, for good or ill, reflects not only on oneself, but more significantly, on the family at large. There is a strong reluctance to allow problems to surface publicly, which might betray "weakness," unhappiness, or division within the family.

This reluctance is further fostered by long-standing Buddhist and Confucian patterns of conduct that encourage passivity, stoicism, and personal reserve. Dr. Tran Minh Tung, a noted Vietnamese psychiatrist, predicted in 1975:

"Most probably the unhappiness will be suffered in silence and in private: crying alone at night or just staying awake, remembering and regretting and feeling loneliness and emptiness."

The traditional cultural patterns of familial loyalty and interdependence, as well as personal restraint, have inhibited the use of mental health services and prevented any accurate assessment of the full range and scope of Indochinese refugees' mental health needs. Enough is known, however, to assert that while the mental health services may be under-used, Indochinese refugees are experiencing considerable emotional troubles in making the adjustment to American life. The troubles of the refugees grow out of the loss of one home and the enormous difficulties of adjusting to another. The depression and anxiety that is so frequently reported reflects a profound instability in the refugees' situation, not an inherent instability in the refugees themselves. Drs. Segal and Lourie, quoted previously, describe the refugees' situation this way:

"...the precipitous departure from home and homeland is likely to evoke the anxiety and insecurity inherent in the new and unknown. These responses will often be reinforced by events; the sense of isolation and abandonment felt by many refugees will be heightened in the face of a predictable avalanche of family, social, vocational, and economic problems."

Some of the sources of stress were identified in a 1976 study done by an HEW organized Mental Health Task Force for Indochinese Refugees: ^{*/}

^{*/} This task force was established by HEW's Region IX Alcohol, Drug Abuse, and Mental Health (ADAMH) Branch.

- Marked cultural differences
- Communication difficulties
- Trauma of suddenly losing one's homeland and roots
- Shock of separation from family
- Future uncertainties
- Unavailability of jobs, particularly those commensurate with previous training and experience
- Inadequate living arrangements
- Conflict with sponsors
- Breakdown in traditional family structure, caused by generational conflict

The study conducted by the Pennsylvania Office of Mental Health, Bureau of Research and Training, identified the following emotional troubles, listed in order of frequency:

- Depression
- Anxiety reactions
- Marital conflict
- Intergenerational conflict
- School adjustment problems
- Psychosomatic illnesses, including fatigue, dizziness, weight loss, nausea, headaches, chest pains and insomnia.

The majority of organizations involved in refugee mental health care that were surveyed in the study by the Pennsylvania Office of Mental Health, reported an overall increase in adjustment problems in the past year. Some of the individuals surveyed felt that this increase was due, in part, to the fact that the emotional troubles of the refugees who arrived in the United States in 1975 and 1976 were only beginning to surface now. A preliminary study undertaken

by the International Institute of San Francisco, under one of the IRAP-funded mental health project grants, offers this analysis:

"Beginning with the thirteenth month [after arrival in the US] and increasing in frequency, depression is the most frequently noted problem. Among those persons who had lived in the Bay Area for more than two and a half years, depression was noted...in 92% of the cases. This implies that after an initial period of adjustment during which basic needs predominate, refugees' psychological problems related to loss begin to appear with increasing frequency."

This delayed reaction may be evidence of what has been called a "survivor syndrome." During the initial period of resettlement, the refugees are preoccupied with satisfying their basic needs: food, clothing, shelter, and some form of employment. Their attention is focused on the day to day considerations of rebuilding a home. It is only later--sometimes years later--that they begin to take the time to measure their losses, to grieve for their family and friends left behind, and to try to come to grips with the fact that their new situation may be permanent.

The disruption of the extended family, the disintegration of the traditional community support systems, and the pressures of new, more aggressive, individualistic cultural values, have forced many of the Indochinese refugees into an uncomfortable adjustment. The fatalistic, conciliatory attitudes of Buddhism and Confucianism no longer seem to apply, leaving the refugees uncertain as to how to meet the demands of their new life.

C. Refugee Groups with Special Needs

The national study by the Pennsylvania Office of Mental Health identified several sub-groups within the Indochinese refugee population that seemed especially vulnerable to emotional

troubles resulting from the stresses of resettlement and adjustment.

Many of the agencies surveyed in the study expressed concern for a number of the smaller ethnic groups among the refugees--the Khmer, Hmong, Yao, Thai Dam, and Lao Teung, for example. Since Indochinese refugees have tended to settle within their own specific ethnic groups, the traumas of isolation and adjustment are amplified for members of those ethnic groups that have settled here in relatively small numbers.

Refugees resettled in the more remote, rural areas of the United States (especially if they were resettled singly or in very small groups) were also reported to be having more serious adjustment problems. Like the smaller ethnic groups, they suffer from the critical lack of a broad system of community support. Refugees resettled in remote areas of the country often migrate to large metropolitan areas, to be closer to relatives and other members of their ethnic community, and/or to take advantage of a generally wider range of services and job possibilities.

The national study also identified special difficulties encountered by different age groups within the Indochinese population. Refugees between the ages of 19 and 35 are considered to be the most vulnerable to depression and anxiety, particularly the single, unattached men. The emotional troubles among the young single refugees often stem from feelings of rootlessness, and detachment--both from their adopted culture and from the traditional family-oriented structure of the Indochinese communities.

The second most vulnerable group of refugees are those between the ages of 36 and 55. Depression, anxiety and family conflict were

frequently-noted problems in this group as well. Homesickness, bewilderment with a strange culture, and "despair of the future" as one refugee put it, is more acute in many of the older refugees. Refugees over 55 were also found to need special attention. Accustomed to considerable respect and esteem in their homelands, these elder refugees feel increasingly alienated and alone as the younger generations adopt more Westernized values and attitudes, and ignore the counsel and values of the older generation.

Special consideration must also be given to the mental health needs of Indochinese refugee children, particularly those of school age. Refugee children often adapt quite readily to their new environment, showing a remarkable facility with language and other basic skills. Refugee children often find themselves in the unfamiliar position of instructor or translator for their parents and elders. This reversal of roles undermines the traditional pattern of family relationships, and sometimes leads to a breakdown of the authority of the parents--a psychologically risky situation for any child.

D. The Role of Social Services in Refugee Mental Health

Many of those who have studied refugee mental health have come to the conclusion that one of the strongest defenses against depression and mental stress among refugees--one of the best types of "preventive medicine"--is an effective system of social services (such as language training, employment counseling, vocational training, etc.) designed to develop a sense of confidence and self-reliance among the refugees. In this respect, the language and vocational training programs operating around the country, as well as the counseling and educational programs which stress "life

skills" (such as home management, housing, transportation, nutrition, health, etc.) all serve an invaluable role in fostering the refugees' mental and emotional health.

This past September, HEW's Indochinese Refugee Assistance program awarded a total of \$4.2 million in special grants to 52 English language and employment services projects established for the Indochinese refugees. Similar projects have been initiated in some places by state and local agencies using public funds, or by voluntary resettlement agencies relying on private contributions. In addition, IRAP reimburses local agencies under Title XX of the Social Security Act for the participation of Indochinese refugees in social service projects that offer counseling and educational services, language and vocational training, etc. These reimbursements totalled more than \$37 million in fiscal year 1979. Many of these Title XX projects are supplemented by state and private resources as well.

In many instances, there is, of course, no clear line of demarkation between the types of social services described above, and the services offered in the mental health field. In many communities, there are agencies which offer a combination of social services (vocational counseling, "life skills" education, etc.) and more traditional mental health services (personal counseling, family therapy, etc.). Many of the special mental health projects funded by IRAP fall into this category. The thirty-two mental health projects that are currently receiving IRAP funding offer a diverse combination of programs, including short-term research projects, "life skills" education, and vocational and supportive counseling in the course of training bilingual mental health para-professionals.

One of the earliest of the IRAP-funded special mental health projects is the Asian Counseling and Referral Service in Seattle, Washington. With a current staff of 21, including six bilingual Indochinese caseworkers, the project has been providing mental health care to refugees since 1975. The Asian Counseling and Referral Service is capable of responding to a wide range of concerns related to refugee mental health. Indochinese paraprofessional caseworkers provide crisis intervention and supportive counseling in the course of their training. A consulting psychiatrist is available in cases requiring medication or hospitalization. The Seattle project also provides referral services to refugees for language training, employment counseling, and health services.

Dave Okimoto, Director of the Asian Counseling and Referral Service, emphasizes that consideration of the refugee's emotional needs in the earliest stages of the resettlement process is the most effective method of preventing later difficulties. The project has been working with sponsors and the local officials of the voluntary agencies to increase their sensitivity to the special mental health needs of the refugees. The project has also been working within the Indochinese community--providing orientation and supportive counseling, in an effort to develop among the refugees an understanding of life in America.

E. Strategies for Improving Mental Health Care

Efforts to deliver adequate mental health care to Indochinese refugees have been hampered by significant cultural differences, by a scarcity of resources, and by the limited coordination and sharing of information among the many organizations and agencies involved. The

"Mental Health Needs Assessment" study by the Bureau of Research and Training of the Pennsylvania Office of Mental Health, sought to identify the greatest needs in the area of refugee mental health care. The majority of organizations and agencies that responded to this study stressed the need for more intensive research and training in cultural differences, as well as the need for the creation and development of effective systems of community support.

The study found that the principal request made of researchers in the field is that they "provide treatment models effective in counteracting grief and a sense of loss." Most respondents felt that a systematic effort should be made to determine what combinations of counseling services, educational programs, and other therapeutic methods might best enable the refugees to confront the rupture of their earlier lives and their struggles to build a new life in this country.

The majority of those responding to the study indicated that the training of Indochinese mental health professionals and paraprofessionals is fundamental in the development of effective mental health systems for the Indochinese communities. These skilled, bilingual caseworkers, members of the communities themselves, would serve as links between the two cultures.

Most of the respondents also recommended strengthening the indigenous organizations within the Indochinese communities as the most effective way of assisting refugees in their adjustment. The majority viewed the creation of community support systems as the most important objective that the federal government should pursue in determining future refugee mental health funding. Respondents made several suggestions toward this objective -- including the

development of social and recreational centers, as well as preventive mental health programs, organized and staffed by members of the Indochinese community. The geographical clustering of refugees of similar ethnic background during the resettlement process was also encouraged as a way of nurturing the growth of secure Indochinese communities.

In testimony before the House Subcommittee on Immigration, Refugees, and International Law, in May, 1979, Dr. Barry Miller, Director of the Bureau of Research and Training, Pennsylvania Office of Mental Health, presented ten recommendations to improve mental health care not only for Indochinese refugees, but for all who enter the United States:

- (1) Provide orientation programs prior to entry into the United States.
- (2) Provide language and vocational programs prior to entry into this country when and where feasible.
- (3) Allow the refugees to settle within their own communities; when no community exists previously, allow the refugees to develop their own local groups.
- (4) Develop community organizations which will ultimately become service providers.
- (5) Provide money for research to determine those treatment models which will be most effective with specific refugee populations.
- (6) Encourage outreach programs to develop increased cultural understanding among the refugees of Western-oriented mental health care programs.
- (7) Accept traditional and folk medicine as part of our tools for therapeutic intervention.
- (8) Provide bilingual/bicultural staff to our mental health centers.
- (9) Strive for integration of services for refugees with a strong involvement of the refugee community based organizations.

- (10) Train refugees to become professionals and para-professionals in our mental health care programs.

F. Conclusion

Traditional Western techniques of mental health care have commonly focused on individual loss -- loss of confidence, of stability, or loss of a loved one, through alienation or death. The Indochinese refugees confront a shared, communal loss of devastating proportions. In thousands of cases, so much of what these people once knew and cared for is gone: homeland, village, family, friends.

A firm sense of community may be the most precious hope of the Indochinese refugees. To have a strong community, they must first have confidence. To have confidence, they must first have those skills by which they can sustain themselves. To develop these skills there must first be cross-cultural programs -- orientation programs, language and vocational training programs, counseling and educational programs.

Indochinese refugees have already given a great deal to this country, through a sharing of their culture and their commitments. Time and again they have shown their resourcefulness in adapting to new situations and new demands, often with minimal language skills and limited understanding of American culture. They could achieve so much more with a proper, initial foundation in basic cultural skills.

If we make a full, initial commitment to equip the refugees, as rapidly as possible, for life in this country, the returns will be well worth the investment: for the country as a whole, a secure, productive addition to the nation's ethnic diversity; for the Indochinese refugees, a new sense of confidence and permanence.

Glossary of Medical Conditions

- 1) Anemia: A condition in which the number of red blood cells, or the total amount of hemoglobin in the blood stream, is reduced, resulting in headache, weakness, and fatigue. The major cause of anemia in Indochinese refugees is malnutrition caused by an iron-deficient diet.
- 2) Hepatitis B: Also known as serum hepatitis, this is a viral hepatitis characterized by inflammation of the liver, and jaundice. Transmission of the disease can occur through blood transfusion; the use of contaminated surgical equipment, syringes, etc.; or direct contact with the body fluids of someone with hepatitis. The Center for Disease Control reports that preliminary data, based on screening of Indochinese refugees entering Canada, indicates that approximately 12 percent of these refugees are positive for hepatitis B surface antigen (HBsAg). Most of these individuals are only "carriers" of the antigen, and display no symptoms of hepatitis. CDC officials have stated that, "any increased risk of transmitting hepatitis B to the U.S. population is expected to be small."
- 3) Intestinal parasites: The types of intestinal parasites most prevalent among Indochinese refugees are the following: hookworm, Giardia (protozoa), Trichuris (whipworm), and Ascaris (roundworm). Common symptoms of the presence of these parasites include diarrhea, abdominal pains, and loss of weight.
- 4) Leprosy: Also known as Hansen's disease, leprosy is a chronic, infectious, but only minimally contagious disease, caused by bacteria that primarily affect the skin, flesh, and nerves. Cases of leprosy among Indochinese refugees have been extremely rare.
- 5) Malaria: An acute, sometimes chronic, infectious disease characterized by severe chills, high fever, sweating, and, on rare occasions, jaundice. Infection can occur through blood transfusion, but in the vast majority of cases, it is caused by the bite of an infected Anopheles mosquito. The Center for Disease Control feels that the risk of transmission of malaria in the U.S. is small.
- 6) Skin conditions: The most prevalent skin conditions among Indochinese refugees, particularly children, are scabies and impetigo. Scabies is a skin infection caused by the itch mite and is characterized by intense itching and inflammation in the infected areas. Scabies is transmissible but can be controlled with vigorous cleansing and medication. Impetigo is a superficial skin condition caused by bacteria (staphylococci or

*/ In reference to medical conditions, chronic means "lasting a long time or recurring often," while acute means "severe but of short duration."

or streptococci), characterized by pus-filled blisters. Impetigo is particularly contagious among infants and young children, but is easily treated with antibiotics.

- 7) Tuberculosis: An infectious disease caused by the tuberculosis bacterium (tubercle bacillus). This bacteria forms tubercles or nodules, which gradually harden or calcify. Pulmonary tuberculosis, acquired by inhaling the tubercle bacilli, is the most common variety, and primarily affects the respiratory system. The current method of treatment consists of the administration of anti-tuberculous drugs for a period of 12 to 24 months. This treatment is generally highly effective and safe.

Tuberculosis classified as "inactive" indicates a dormant, non-infectious state of the disease. Tuberculosis classified as "active" indicates on-going infection; however, a person with active TB ceases to be infectious after being successfully treated with anti-tuberculous drugs for a period of four to eight weeks. No individuals who have infectious tuberculosis are admitted into this country.

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